

Cert.	Issued
Certificate Mailed	

## APPLICATION FOR LICENSE TO PRACTICE PHYSICIAN ASSISTANT

**South Dakota State Board of Medical and Osteopathic Examiners**

125 S. Main Ave. - Sioux Falls, SD 57104

All applicants for licensure must submit one photograph with the application.

Answer all questions. If answer is "no" or "none," so state.

Please type or print clearly in ink.

If additional space is required, attach separate sheets, indicating section to which they refer.

Social Security # \_\_\_\_\_

Compliance with the Board's request for your Social Security number is **Voluntary**. The use that the Board will make of such Social Security number is the reporting of possible disciplinary actions. The Board's authority to make this request is its inherent authority to regulate physician assistant licensure.

Applications must be accompanied by applicable fees. Fees are non-refundable

Schedule of Fees:	Certification	\$75
	Temporary License	\$50
	Locum Tenens	\$50

Name \_\_\_\_\_

Last	First	Middle	Sex	Birthdate
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Address \_\_\_\_\_

	Citizenship _____
	Birthplace _____

Telephone number (    ) \_\_\_\_\_

Name of Supervising Physician \_\_\_\_\_

Signature of Supervising Physician \_\_\_\_\_

Application if made for licensure by	A. Certification (    )
	B. Locum Tenens (    )
	C. Temporary License (    )

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Color of Eyes: \_\_\_\_\_ Color of Hair: \_\_\_\_\_

Distinguishing Mark (if any): \_\_\_\_\_

(PICTURE)

I certify that the attached photograph is a true likeness of myself. Enter date taken on photograph (within the past 5 years) and sign in ink across the bottom.

**TO BE COMPLETED BY APPLICANT UNDER OATH**

## 1. TRAINING AND EXPERIENCE

List in chronological order all education and experience as a physician assistant, including college and/or university, and practice. Include **ALL** periods of time from the date of graduation from your physician assistant program to the present, whether or not engaged in activities related to medicine.

[illegible]

## 2. LICENSURE

List all licenses applied for or held, currently or in the past.

State or Other	Certificate		Temporary Or Permanent	License Received		Now In Force
	Year	Number		Examination	Other	

## 3. PERSONAL DATA

If any of the following questions are answered "Yes" full details must be furnished on a separate sheet and attached, and shall be considered as part of this application.

Have you ever:

- |   | Yes | No  |
|---|-----|-----|
| 1. Had a license canceled, limited, suspended, or revoked?  | ( ) | ( ) |
| 2. Been subject to proceedings by a licensing agency to cancel, limit, suspend, or revoke a license?  | ( ) | ( ) |
| 3. Been denied licensure in another state?  | ( ) | ( ) |
| 4. Been convicted, or is there now pending any criminal prosecution against you which would constitute a felony, involve your physician assistant practice or involve moral turpitude?                            | ( ) | ( ) |
| 5. Had your hospitalization privileges revoked, reduced or otherwise restricted?  | ( ) | ( ) |
| 6. Been requested to appear, or appeared, before any licensure board concerning any violation by you of any law, rule or regulation or any state, district, territory or province of the United States or Canada? | ( ) | ( ) |
| 7. Been subject to proceedings by a professional society to revoke, reduce, or restrict membership?   | ( ) | ( ) |
| 8. Been notified of a complaint by a medical facility, professional society or association, or any licensing agency?  | ( ) | ( ) |
| 9. Settled a civil damages action, by the payment of money or otherwise, or had a civil judgment rendered against you involving malpractice or your practice as a physician assistant?                            | ( ) | ( ) |
| 10. In the last five (5) years, have you:   |     |     |
| a. Been treated, hospitalized, or confined for:   |     |     |
| 1. Alcoholism or alcohol abuse?   | ( ) | ( ) |
| 2. Drug use?  | ( ) | ( ) |
| 3. Mental illness?  | ( ) | ( ) |

If you answered "YES" to questions 1 through 10 above, provide specific information: \_\_\_\_\_

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## AFFIDAVIT

I, \_\_\_\_\_, being first duly sworn depose and say that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of South Dakota; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to this licensing Board any information, files or records required by the Board for its evaluation of my professional, ethical and physical qualifications for licensure in South Dakota.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice as a physician assistant in the State of South Dakota.

\_\_\_\_\_  
Signature of Applicant

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

(SEAL)

My Commission expires: \_\_\_\_\_

## CERTIFICATION

(Board with whom reciprocity is requested to please fill in subjects and grades and certify thereto; or request that certification with examination scores be sent directly to the South Dakota Board from the National Commission on Certification of Physician Assistants.)


Total \_\_\_\_\_ Average \_\_\_\_\_

I certify that the ratings herein given are true and correct and that no license issued by this Board to \_\_\_\_\_  
\_\_\_\_\_ has ever been revoked  
suspended and that from the records of this office I believe him/her to be of good moral character and worthy  
recognition by the South Dakota Board. In testimony whereof witness my hand and seal:

(SEAL)

\_\_\_\_\_  
Secretary of the \_\_\_\_\_ State  
Board of \_\_\_\_\_  
Address \_\_\_\_\_  
Date \_\_\_\_\_